Physician Services: the following services, performed by a Physician within the scope of his or her license, training and specialty and within the scope of generally acceptable medical standards as determined by the Corporation:

1. Office visits, which are for the purpose of seeking or receiving care for an illness or injury;

2. Basic diagnostic services and machine tests;

3. Physician Services include the following services when performed by a medical doctor, osteopath, podiatrist or oral surgeon, but specifically excluding such services when performed by a chiropractor, optometrist, or licensed psychologist with a doctoral degree:

   a. Benefits rendered to a Member in a Hospital or Skilled Nursing Facility;

   b. Benefits rendered in a Member's home;

   c. Surgical Services;

   d. Anesthesia services, including the administration of general or spinal block anesthesia;

   e. Radiological examinations;

   f. Laboratory tests; and,

   g. Maternity services, including consultation, prenatal care, conditions directly related to pregnancy, delivery and postpartum care, and delivery of one or more infants. Physician Services also include maternity services performed by certified nurse midwives when supervised by a medical doctor.

Plan: any program that provides benefits or services for medical or dental care or treatment including:

1. Group coverage, whether insured or self-insured. This includes, but is not limited to, prepayment, group practice or individual practice coverage; and

2. Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

3. Each contract or other arrangement for coverage is a separate Plan for purposes of this Plan of Benefits. If a Plan has two (2) or more parts and the coordination of benefit rules in Article V apply only to one (1) of the parts, each part is considered a separate Plan.

Plan Administrator: the entity charged with the administration of this Plan of Benefits. The Employer is the Plan Administrator of this Plan of Benefits.

Plan of Benefits: this Preferred Blue Plan of Benefits including the Employer Application, the Membership Application, the Schedule of Benefits, and all endorsements, amendments, riders, or addendums.

Plan of Benefits Effective Date: 12:01 AM on the date listed on the Schedule of Benefits.

Post-Service Claim: any claim for a Benefit that is not a Pre-Service Claim.

Preadmission Review: the review that must be obtained by a Member (or the Member's representative) prior to all Admissions that are not related to an Emergency Medical Condition. The Preadmission Review process is outlined in Article III.

Pre-Authorized/Pre-Authorization: the Corporation's approval of Benefits based on Medical Necessity prior to the rendering of such Benefits to a Member. Pre-Authorization means only that the Corporation has determined that the Benefit is Medically Necessary. Pre-Authorization is not a guarantee of payment or a verification that Benefits will be paid or are available to the Member. Payment for Benefits is also subject to a Member's eligibility, Pre-Existing Condition Limitations and all other limitations and exclusions contained in this Plan of Benefits. A Member's entitlement to Benefits is not determined until the Member's claim is processed. The Pre-Authorization process is outlined in Article III.

Pre-Existing Condition: a physical or mental condition for which medical advice, diagnosis, care or treatment was received or recommended during the six (6) month period preceding the Enrollment Date, if applicable. Genetic Information may not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to the Genetic Information.

Pre-Existing Condition Waiting Period: the period (as set forth on the Schedule of Benefits) during which this Plan of Benefits will not provide Benefits to a Member for Pre-Existing Conditions, not to exceed twelve (12) months without medical care, treatment or supplies ending after the Member Effective Date of coverage or twelve (12) months after the Enrollment Date, whichever occurs first or eighteen (18) months after the Enrollment Date for a late enrollee.

Preferred Brand Drug: a Prescription Drug that bears a recognized brand name of a particular manufacturer and appears on the list of Preferred Brand Drugs.

Preferred Drug: a Prescription Drug that has been reviewed for cost effectiveness, clinical efficacy and quality that is preferred by the Pharmacy Benefit Manager, for dispensing to Members. Preferred Drugs are subject to periodic review and modification by the Corporation, or its designated Pharmacy Benefit Manager, and include Brand Name Drugs and Generic Drugs.

Premium: the amount paid to the Corporation by the Employer on the Members' behalf for coverage under this Plan of Benefits. Payment of Premiums by the Employer constitutes acceptance by the Employer of the terms of this Plan of Benefits and the Contract.

Prescription Drug: a drug or medicine that is:

1. Required to be labeled that it has been approved by the Food and Drug Administration; and,

2. Bears the legend "Caution: Federal Law prohibits dispensing without a prescription" prior to being dispensed or delivered, or labeled in a similar manner; or,

3. Insulin.

Additionally, to qualify as a Prescription Drug, the drug must:

1. Be ordered by a medical doctor or oral surgeon as a prescription; and,

2. Not be entirely consumed at the time and place where the prescription is dispensed; and,

3. Be purchased for use outside a Hospital.

Prescription Drug Copayment: the amount payable, if any, set forth on the Schedule of Benefits, by the Member for each Prescription Drug filled or refilled. This amount will not be applied to the Benefit Year Deductible or the Out-of-Pocket Maximum.

Pre-Service Claim: any request for a Benefit where Pre-Authorization must be obtained before receiving the medical care, service or supply.

Primary Plan: a Plan whose benefits must be determined without taking into consideration the existence of another Plan.

Probationary Period: the period of continuous employment (if included on the Schedule of Benefits) with the Employer that an Employee must complete before becoming eligible to enroll in this Plan of Benefits.

Prosthetic Device: any device that replaces all or part of a missing body organ or body member, except a wig, hairpiece or any other artificial substitute for scalp hair.

Protected Health Information: has the same meaning as the term is defined under HIPAA.

Provider: any person or entity licensed by the appropriate state regulatory agency and legally engaged within the scope of such person or entity's license in the practice of any of the following:

1. Medicine
2. Dentistry
3. Optometry
4. Podiatry
5. Chiropractic services
6. Behavioral Health
7. Physical therapy
8. Oral surgery
9. Speech therapy
10. Occupational therapy

The term Provider also includes a Hospital, a Rehabilitation Facility, a Skilled Nursing Facility and nurses practicing in expanded roles (such as pediatric nurse practitioners, family practice nurse practitioners and certified nurse midwives) when supervised by a medical doctor or oral surgeon. The term Provider does not include physical trainers, lay midwives, or masseuses.

Qualified Medical Child Support Order: a Medical Child Support Order that:

1. Creates or recognizes the existence of an Alternate Recipient's right to enroll under this Plan of Benefits; or,
2. Assigns to an Alternate Recipient the right to enroll under this Plan of Benefits.

Qualifying Event: for continuation of coverage purposes under Article VII, a Qualifying Event is any one of the following:

1. Termination of the Employee's employment (other than for gross misconduct) or reduction of hours worked that renders the Employee no longer Actively at Work and therefore ineligible for coverage under this Plan of Benefits;

2. Death of the Employee;

3. Divorce or legal separation of the Employee from his or her spouse;

4. A Child ceasing to qualify as a Dependent under this Plan of Benefits;

5. Entitlement to Medicare by an Employee, or by a parent of a Child;

6. A proceeding under Title II of COBRA with respect to the Employer from whose employment an Employee retired at any time.

Rehabilitation Facility: licensed facility operated for the purpose of assisting Members with neurological or other physical injuries to recover as much restoration of function as possible.

Schedule of Benefits: the pages of this Plan of Benefits so titled, which specify the coverage provided and the applicable Copayments, Coinsurance, Benefit Year Deductibles and Benefit limitations.

Secondary Plan: a Plan that is not a Primary Plan. When this Plan of Benefits constitutes a Secondary Plan, availability of Benefits are determined after those of the other Plan and may be reduced because of benefits payable under the other Plan.

Skilled Nursing Facility: an institution other than a Hospital that is certified and licensed by the appropriate state regulatory agency as a skilled nursing facility.

Special Care Unit: a specially equipped unit of a Hospital, set aside as a distinct care area, staffed and equipped to handle seriously ill Members requiring extraordinary care on a concentrated and continuous basis, such as burn, intensive, or coronary care units.

Special Enrollment: the time period during which an Employee or eligible Dependent who is not enrolled for coverage under this Plan of Benefits may enroll for coverage due to the involuntary loss of other coverage or under permitted circumstances described in Article II of this Plan of Benefits.

Specialist: a Physician that specializes in a particular branch of medicine.

Specialty Drugs: Prescription Drugs that treat a complex clinical condition and/or require special handling such as refrigeration. They generally require complex clinical monitoring, training and expertise. Specialty drugs include, but are not limited to infusible specialty drugs for chronic diseases, injectable and self-injectable drugs for acute and chronic diseases, and specialty oral drugs. Specialty drugs are used to treat acute and chronic disease states (e.g. growth deficiencies, Hemophilia, Multiple Sclerosis, Rheumatoid Arthritis, Gaucher's Disease, Hepatitis, cancer, organ transplantation, Alpha 1-Antitrypsin Disease and immune deficiencies).

Substance Abuse: the continued use, abuse and/or dependence of legal or illegal substance(s), despite significant consequences or marked problems associated with the use (as defined, described, or classified in the most current version of *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.)

Substance Abuse Services: services or treatment relating to Substance Abuse.

Surgical Services: an operative or cutting procedure or the treatment of fractures or dislocations. Surgical Services include the usual, necessary and related pre-operative and post-operative care when performed by a medical doctor or oral surgeon.

Totally Disabled/Total Disability: means that the Member is able to perform none of the usual and customary duties of such Member's occupation. With respect to a Member who is a Dependent, the terms refer to disability to the extent that such Member can perform none of the usual and customary duties or activities of a person in good health of the same age. The Member must provide a Physician's statement of disability upon periodic request by the Corporation.

Urgent Care Claim: any claim for medical care or treatment where making a determination under other than normal time frames could seriously jeopardize the Member's life or health or the Member's ability to regain maximum function; or, in the opinion of a medical doctor or oral surgeon with knowledge of the Member's medical condition, would subject the Member to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.

USERRA: The Uniformed Services Employment and Reemployment Rights Act of 1994 including any amendments thereto.

ARTICLE II – ELIGIBILITY FOR COVERAGE

A. ELIGIBILITY

1. Every Employee who is Actively at Work and who has completed the Probationary Period on or after the Employer Effective Date is eligible to enroll (and to enroll such Employee's Dependents) for coverage under this Plan of Benefits.

2. If an Employee is not Actively at Work or has not completed the Probationary Period such Employee is eligible to enroll (and to enroll such Employee's Dependents) beginning on the next day that the Employee is

   a. Actively at Work; and

   b. Has completed the Probationary Period.

3. Dependents are not eligible to enroll for coverage under this Plan of Benefits without the sponsorship of an Employee who is enrolled under this Plan of Benefits.

B. PRE-EXISTING CONDITION WAITING PERIOD

This Plan of Benefits will not pay Covered Expenses during a Member's Pre-Existing Condition Waiting Period. The Pre-Existing Condition Waiting Period is reduced by the aggregate of any periods of Creditable Coverage immediately prior to the Member Effective Date in accordance with section C, below.

The Pre-Existing Condition Waiting Period does not apply to the following:

1. Genetic Information unless there is a diagnosis of a condition related to that Genetic Information;

2. Pregnancy;

3. Newborns who have Creditable Coverage within thirty-one (31) days of birth, so long as there has been no break in coverage of sixty-three (63) days or more;

4. An adopted Child, or a Child placed for adoption before age eighteen (18), if the Child has Creditable Coverage within thirty-one (31) days of the adoption or placement for adoption, so long as there has been no break in coverage of sixty-three (63) days or more; or,

5. The Prescription Drug Benefit if such Benefit is included on the Schedule of Benefits; or,

6. Any gap period between an initial COBRA Qualifying Event and the first day of a special COBRA election period under the Trade Act of 2002.

The Member will be notified if any Pre-Existing Condition Waiting Period applies to the Member and how this determination was made.

C. CREDITABLE COVERAGE

1. Evidence of Creditable Coverage may reduce the length of the Member's Pre-Existing Condition Waiting Period. If a Member had Creditable Coverage immediately prior to the Member Effective Date, and there was no break in coverage for a period of sixty-three (63) consecutive days or more following prior Creditable Coverage, the Pre-Existing Condition Waiting Period will be reduced by the aggregate number of days of Creditable Coverage. A Probationary Period does not count as a break in Creditable Coverage. Excepted Benefits do not count as Creditable Coverage.

2. To receive credit for Creditable Coverage, the Member must provide the Corporation with a Certificate of Creditable Coverage or other acceptable evidence of Creditable Coverage. A Member has the right to request a Certificate of Creditable Coverage from any prior Group Health Plan or individual health plan. If requested by the Member in writing, the Corporation will request a Certificate of Creditable Coverage for the Member.

3. If the Member does not agree with the Corporation's decision with respect to prior Creditable Coverage, the Member has the right to send the Corporation additional evidence of Creditable Coverage. Decisions regarding Pre-Existing Condition Waiting Periods may be reconsidered by the Corporation.

4. To request a Certificate of Creditable Coverage from the Corporation the Member must call Customer Service at the number listed on the Identification Card.

5. The Corporation will automatically issue Certificates of Creditable Coverage to any Members that terminate under this Plan of Benefits.

D. ELECTION OF COVERAGE

Any Employee may enroll for coverage under this Plan of Benefits for such Employee and such Employee's Dependents by completing and filing a Membership Application with the Employer. Dependents must be enrolled within thirty-one (31) days of the date on which they first become Dependents. Employees and Dependents may also enroll if eligible under the terms of any late enrollment or special enrollment procedure.

E. COMMENCEMENT OF COVERAGE

Coverage under this Plan of Benefits will commence as follows:

1. Employees and Dependents Eligible on the Employer's Effective Date

   For Employees (and such Employee's Dependents for whom such Employee has elected coverage) who are Actively at Work prior to and on the Employer Effective Date, coverage will generally commence on this Plan of Benefits Effective Date.

   If the Corporation receives an Employee's Membership Application dated after the Employer Effective Date, coverage will commence on the date chosen by the Employer. Notwithstanding the preceding sentence, coverage will not be effective more than sixty (60) days before the Corporation receives such Employee's Membership Application.

2. Employees and Dependents Eligible After this Plan of Benefits Effective Date

   Employees and Dependents who become eligible for coverage after this Plan of Benefits Effective Date and have elected coverage, will have coverage after they have completed the Probationary Period. Notwithstanding the preceding sentence, coverage will not be effective more than sixty (60) days before the Corporation receives such Employee's Membership Application.

3. Dependents Resulting from Marriage

   Dependent(s) resulting from the marriage of an Employee will have coverage upon enrollment provided they have been enrolled for coverage within thirty-one (31) days after marriage and appropriate Premiums must be paid to the Corporation for such Dependent(s) to have coverage from the date of the marriage.

4. Newborn Children

   A newborn Child will have coverage upon enrollment provided he or she have enrolled for coverage (and the coverage has been paid for) within thirty-one (31) days after the Child's birth.

5. Adopted Children

   For an adopted Child of an Employee, coverage shall commence as follows:

   a. Coverage shall be retroactive to the Child's date of birth when a decree of adoption is entered within thirty-one (31) days after the date of the Child's birth;

   b. Coverage shall be retroactive to the Child's date of birth when adoption proceedings have been instituted by the Employee within thirty-one (31) days after the date of the Child's birth, and if the Employee has obtained temporary custody of the Child;

   c. For an adopted Child other than a newborn, coverage shall begin when temporary custody of the Child begins. However, such coverage shall only continue for one (1) year unless a decree of adoption is entered in which case coverage shall be extended so long as such Child is otherwise eligible for coverage under the terms of this Plan of Benefits.

   If an adopted Child is not enrolled within the time frame set forth in (a)-(c) above, coverage will begin on the date chosen by the Employer and upon the payment of the applicable Premium.

6. Special Enrollment

In addition to enrollment under Article II(E)(2-5), the Corporation shall permit an Employee or Dependent who is not enrolled to enroll if each of the following is met:

a. The Employee or Dependent was covered under a Group Health Plan or had Creditable Coverage at the time coverage was previously offered to the Employee or Dependent; and

b. The Employee stated in writing at the time of enrollment, that the reason for declining enrollment was because the Employee or Dependent was covered under a Group Health Plan or had Creditable Coverage at that time. This requirement shall only apply if the Employer required such a statement at the time the Employee declined coverage and provided the Employee with notice of the requirement and the consequences of the requirement at the time; and

c. The Employee or Dependent's coverage described above:

i. Was under a COBRA continuation provision and the coverage under the provision was exhausted; or

ii. Was not under a COBRA continuation provision described in section 6(c)(i), above, and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment), or reduction in the number of hours of employment, or if the employer's contributions toward the coverage were terminated; or

iii. Was one of multiple Plans offered by an employer and the Employee elected a different plan during an open enrollment period or when an employer terminates all similarly situated individuals; or

iv. Was under a HMO that no longer serves the area in which the Employee lives, works or resides; or

v. Was under a Plan where the Member incurs a claim that would meet or exceed a lifetime limit on all benefits. The Special Enrollment period is continued until at least thirty (30) days after a claim is denied due to the operation of the lifetime limit on all benefits.

vi. Under the terms of the Plan, the Employee requests the enrollment not later than thirty-one (31) days after date of exhaustion described in 6(c)(i) above, or termination of coverage or Employer contribution described in 6(c)(ii) above.

The above list is not an all-inclusive list of situations when an Employee or Dependent loses eligibility. For situations other than those listed above see the Employer.

F. DEPENDENT CHILD'S ENROLLMENT

1. A Dependent Child will not be denied enrollment for any of the following reasons:

a. Being born out of wedlock;

b. Not being claimed as a Dependent on the Employee's federal tax return; or,

c. Not residing with the Employee.

2. A Dependent's eligibility for or receipt of Medicaid assistance will not be considered in enrolling that Dependent for coverage under this Plan of Benefits. For a Dependent to be covered under this Plan of Benefits, the required Premium must be paid.

G. DISCLOSURE OF MEDICAL INFORMATION

By accepting Benefits or payment of Covered Expenses, the Member agrees that the Corporation may obtain claims information, medical records, and other information necessary for the Corporation to consider a request for Pre-Authorization or Continued Stay Review, or Emergency Admission Review, or Preadmission Review or to process a claim for Benefits.

ARTICLE III – BENEFITS

A. PAYMENT

The payment of Covered Expenses for Benefits is subject to all terms and conditions of this Plan of Benefits and the Schedule of Benefits. The total amount paid for Benefits shall not exceed the Lifetime Maximum and in the event that a Member reaches the Lifetime Maximum, no further Benefits will be paid under this Plan of Benefits. In the event of a conflict between this Plan of Benefits and the Schedule of Benefits, the Schedule of Benefits controls. Covered Expenses will only be paid for Benefits:

1. Performed or provided on or after the Member Effective Date; and

2. Performed or provided prior to termination of coverage; and

3. Provided by a Provider, within the scope of his or her license; and

4. For which the appropriate Preadmission Review, Emergency Admission Review, Pre-Authorization and/or Continued Stay Review has been requested and Pre-Authorization was received from the Corporation; and

5. That are Medically Necessary; and

6. That are not subject to an exclusion under Article IV of this Plan of Benefits; and

7. After the payment of all required Benefit Year Deductibles, Coinsurance and Copayments.

B. PRE-AUTHORIZATION

All Admissions and some Benefits (as indicated herein or on the Schedule of Benefits) require Pre-Authorization to determine the Medical Necessity of such Admission or Benefit. The Corporation reserves the right to add or remove items from the list of Benefits that are subject to Pre-Authorization. Each Member is responsible for obtaining Pre-Authorization and the appropriate review. If Pre-Authorization is not obtained for an Admission or if an Admission is not Pre-Authorized, and the Member is still admitted, Benefits will be reduced (up to and including denial of all or a portion of the room and board charges associated with the Admission). Specific penalties for outpatient services, Mental Health Services, Mental Health Conditions and Substance Abuse Services are listed on the Schedule of Benefits. Pre-Authorization is obtained through the following procedures:

1. For all Admissions, that are not the result of an Emergency Medical Condition, Pre-Authorization is granted or denied in the course of the Preadmission Review;

2. For all Admissions, that result from an Emergency Medical Condition, Pre-Authorization is granted or denied in the course of the Emergency Admission Review;

3. For Admissions that are anticipated to require more days than approved through the initial review process, Pre-Authorization is granted or denied for additional days in the course of the Continued Stay Review; and,

4. For specific Benefits that require Pre-Authorization, Pre-Authorization is granted or denied in the course of the Pre-Authorization process.

5. For items requiring Pre-Authorization, the Corporation must be called at the number given on the Identification Card.

C. ASSIGNMENT OF COVERED EXPENSES

Payment for Covered Expenses may not be assigned to Non-Participating Providers.

D. SPECIFIC COVERED BENEFITS

If all of the following requirements are met the Corporation will provide the Benefits described and listed under Article III (E).

1. All of the requirements of this Article III must be met.

2. The Benefit must be listed in this Article III.

3. The Benefit must not have a "**Non-Covered**" notation associated with it on the Schedule of Benefits.

4. The Benefit (separately or collectively) must not exceed the dollar or other limitations contained on the Schedule of Benefits.

5. The Benefit must not be subject to one or more of the exclusions set forth in Article IV.

E. BENEFITS

ALLERGY INJECTIONS

The Corporation will pay Covered Expenses for allergy injections as set forth below:

1. For patients with demonstrated hypersensitivity that cannot be managed by medications or avoidance; and,

2. To ensure the potency and efficacy of the antigens, the provision of multiple dose vials is restricted to sufficient antigen for the lesser of a twelve (12) week or twenty-four (24) dose; and,

3. When any of the following conditions are met:

   a. The patient has symptoms of allergic rhinitis and/or asthma after natural exposure to the allergen; or,

   b. The patient has a life threatening allergy to insect stings; or,

c. The patient has skin test and/or serologic evidence of a potent extract of the antigen; or,

d. Avoidance or pharmacologic (drug) therapy cannot control allergic symptoms.

AMBULANCE

The Corporation will pay Covered Expenses for ambulance transportation (including air ambulance when necessary) when used:

1. Locally to or from a Hospital providing Medically Necessary service in connection with an accidental injury or that is the result of an Emergency Medical Condition; and,

2. To or from a Hospital in connection with an Admission.

CHIROPRACTIC SERVICES

If specifically included on the Schedule of Benefits as a Benefit and such item does not have a "Non-Covered" notation, the Corporation will pay Covered Expenses for services and Medical Supplies required in connection with the detection and correction, by manual or mechanical means, of structural imbalance, distortion, or subluxation in the human body, for purposes of removing nerve interference and the effects of such nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

CLEFT LIP OR PALATE

The Corporation will pay Covered Expenses for the care and treatment of a congenital cleft lip or palate, or both, and any physical condition or illness that is related to or developed as a result of a cleft lip or palate.

Benefits shall include, but not be limited to:

1. Oral and facial Surgical Services, surgical management and follow-up care;

2. Prosthetic Device treatment such as obdurators, speech appliances and feeding appliances;

3. Orthodontic treatment and management;

4. Prosthodontia treatment and management;

5. Otolaryngology treatment and management;

6. Audiological assessment, treatment, and management, including surgically implanted amplification devices; and

7. Physical therapy assessment and treatment.

Benefits for a cleft lip or palate must be Pre-Authorized. If a Member with a cleft lip or palate is covered by a dental policy, then teeth capping, prosthodontics, and orthodontics shall be covered by the dental policy to the limit of coverage provided under such dental policy prior to coverage under this Plan of Benefits. Covered Expenses for any excess medical expenses after coverage under any dental policy is exhausted shall be provided as for any other condition or illness under the terms and conditions of this Plan of Benefits.